UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF WISCONSIN

SHEILA A. GARD,

Plaintiff,

COMMON GROUND HEALTHCARE COOPERATIVE,
MOLINA HEALTHCARE OF WI, INC.,
FOUNDERS INSURANCE COMPANY,

Involuntary Plaintiffs,

-vs- Case No. 2:20-CV-256

UNITED STATES OF AMERICA,
UNITED STATES POSTAL SERVICE,
MARK CZECHOLINSKI,

Defendants.

Video Examination of SHEKHAR DAGAM, M.D., taken at the instance of the Plaintiff, under and pursuant to the Federal Rules of Civil Procedure, before Sarah M. Gilkay, a Certified Realtime Reporter, Registered Merit Reporter, and Notary Public in and for the State of Wisconsin, at 4600 W. Loomis Road, Suite 101, Greenfield, Wisconsin, on February 23rd, 2022, commencing at 3:34 p.m. and concluding at 5:15 p.m.

A P P E A R A N C E S

GRUBER LAW OFFICES, LLC, by
Mr. Eric M. Knobloch
100 East Wisconsin Avenue - Suite 2800
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Appeared on behalf of the Plaintiff.

UNITED STATES ATTORNEY - EASTERN DISTRICT, by
Mr. Brian E. Pawlak
517 East Wisconsin Avenue
Milwaukee, Wisconsin 53202
Appeared on behalf of the Defendants.

* * * * *

A L S O P R E S E N T

Mr. Keke M. Lewandowski, paralegal

Mr. Jay Church, videographer

* * * * *

I N D E X

E X A M I N A T I O N

E X H I B I T S

TRANSCRIPT OF PROCEEDINGS

THE VIDEOGRAPHER: Good afternoon. We're going on the record. The time is 3:34 p.m. Today is Wednesday, February 23rd, 2022. Please silence phones and other devices not being used for the deposition, as they can interfere with the recorded audio. The deposition will continue to be recorded until all parties agree to go off the record.

This is media unit number one of the recorded deposition of Dr. Shekhar Dagam. This is taken in the matter of Sheila A. Gard, et al., versus United States of America, et al. This case is filed in the U.S. District Court for the Eastern District of Wisconsin, Case No. 2:20-CV-256.

Our deposition is being held at 4600 West Loomis Road, Suite 101, Greenfield, Wisconsin, 53220.

I'm not authorized to administer an oath, I'm not related to any party in the action, nor am I financially interested in the outcome.

If we can have counsel state their appearances and affiliation for the record,

beginning with the noticing attorney, and then the court reporter will swear in the witness.

MR. KNOBLOCH: Eric Knobloch from Gruber Law Offices here on behalf of the plaintiff, Sheila Gard.

MR. PAWLAK: The defendant appears by Assistant United States Attorney Brian Pawlak. Also present is a paralegal from our office, Keke Lewandowski, common and ordinary spelling.

SHEKHAR DAGAM, M.D., called as a witness herein, having been first duly sworn on oath, was examined and testified as follows:

EXAMINATION

BY MR. KNOBLOCH:

Q Hello, Dr. Dagam. We're here today to talk about the care and treatment of Ms. Sheila Gard, including the treatment that you provided, with respect to an auto accident that occurred on March 24th of 2017. We're going to get into that treatment, but before we do so I would like to provide you an opportunity to introduce yourself to the Court.

What is your occupation and your specialty, please?

A Yeah. My name is Shekhar Dagam. I'm a

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neurosurgeon, and my occupation is surgery of different aspects of the central nervous system.

Q How long have you been a neurosurgeon?

A I've been in practice for over 20 years.

Q What I have marked in front of you, Exhibit No. 7, appears to be your CV.

Would you agree with that?

A Yes.

Q Did you have a chance to look over that in the few minutes before today's deposition?

A I did.

Q And it appears to me that the board certification area, this version that we're looking at ends in 2018.

Have you maintained your board certification from 2018 to the present, and are you currently board-certified?

A Yeah. Unfortunately the CV I think is an older version, and so I'm board-certified currently. It actually even has the business address as a different address.

Q Where did you do your undergrad and your medical training and residency, please?

A I did my undergrad at University of California-Berkeley. I did my medical school at

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George Washington University. And then I did my neurosurgery training at the Mayo Clinic, and then I did some time for an intra-residency fellowship at the University of Pittsburgh Department of Neurosurgery.

Q I may have already asked you this. How long have you been employed as a neurosurgeon?

A I've been practicing neurosurgery since I graduated from my residency program in 2001.

Q Give us some perspective as to your average week or your average month, how often are you -- do you have surgery days versus clinic days, and how many surgeries would you say you perform on an average week?

A Yeah. So my practice is approximately 50 percent surgery, 50 percent clinic. So I will spend between two to three days in the OR per week, and then alternate weeks I would be two to three days in the clinic. The average number of surgeries I do varies from year-to-year. There were years where I was doing 10 to 12 surgeries a week. Now it's closer to 6 to 8 per week.

Q Do you maintain privileges at any hospitals and, if so, where?

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A I currently have privileges at Columbia St. Mary's Ascension in Downtown Milwaukee. I'm also -- I have privileges at the sister hospital, which is in Ozaukee, Columbia St. Mary's Ozaukee. I have privileges at Watertown Memorial Hospital in the city -- in the town of Watertown. And then there is an outpatient surgery center called Milwaukee Surgical Suites where I have privileges as well.

Q We're here today to talk about treatment that was received by Ms. Gard due to that March 24 of '17 accident. Throughout the course of this time period from that accident forward, have you had an opportunity to draft a report, and is that your report in front of you as Exhibit 8?

A Yes, it is.

Q Based on your report or your other knowledge, what is your understanding of the accident that Ms. Gard was in?

A Well, she was in an accident which caused her to have neck pain.

Q Taking a look at your report there, Doctor, I'm going to ask you a very general question, then we're going to get into the specifics of treatment.

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What are the injuries that Ms. Gard sustained in the accident that ultimately led to the cervical fusion that you performed?

A So she developed neck pain after the car accident, and -- and she ultimately ended up having both non-surgical and surgical treatment for the neck pain.

Q What I've shown you -- or showing you here, Doctor, has been marked as Exhibit 3. What I did was take out some records from what will be Plaintiff's Exhibit No. 1, which is the certified medical records, and I took out records that I think you and I will talk about today. I highlighted some areas that I think may be a topic of discussion, and I also Bates stamped in the lower right-hand corner for the sake of our discussion today, so we don't have to flip around as much.

With that being said, I would like for you to take a look at the first Bates stamped page number 1.

Do you have that in front of you?

A I do.

Q All right. And this appears to be an urgent care clinic from the date of the accident,

Page 10

March 27th of 17.
Can you tell from this document, Doctor, what pain complaints Ms. Gard was reporting at that time?
A Yeah. She said that she was having bilateral shoulder pain, as well as pain on the left side of her head, and then she said additionally pain included neck pain.
Q If you can flip the page to Bates stamp number 2 there, this appears to be dated March 30th of '17. The note is with a Dr. Amy Swift-Johnson. Do you know her?
A Not personally.
Q All right. Can you explain the symptoms that she appeared she was having at that visit, please.
A The doctor reports in here that she was having continued bilateral neck pain, which is neck pain on both sides. It was worse on the right side. She was having pain also going into the shoulder blades and going down the back.
Q Okay. Would it be reasonable at that point based on what you know, Doctor, for Ms. Gard to undergo a series of physical therapy?
A Yes. It would be very reasonable.

Page 11

Q All right. What I would like to do is show you Exhibit No. 4. We're going to go back to 3, but let's just switch to 4. All right.
Do you see that note, Doctor?
A Yes.
Q And what's the date on that note?
A April 30th, 2018.
Q All right. I think I went out of order just a bit. In any event, we're going to get to -- well, no. Let's stick on Exhibit No. 4.
What is the referral at that point from the -- from the physician, based on Exhibit 4?
A Yeah. So in this note she recommends or says that she can follow up with pain management.
Q This is missing some pages. That's okay.
You're aware of Dr. Ong?
A Yes.
Q Who is Dr. Ong, and how do you know him?
A So Dr. Ong is a physician who practices in pain management. He works out of Aurora Lakeland Hospital.
Q Do you have a referral relationship with Dr. Ong?
A Yes. Yes, we do.

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Q Okay. What I would like to draw your attention to now is number 10 on Exhibit 3. This appears to be date of service from June of 2018.
Do you see that?
A I do.
Q And under the operative procedure it says "medial branch nerves."
Can you tell from this what procedure it is that Dr. Ong is performing here?
A Yeah. He's doing a block of the pain nerve endings or fibers that go to the facet joints at C4-5, C5-6, and so he calls it a medial branch block.
Q In your opinion what is the objective of such a procedure?
A The objective is to identify the location of the neck pain. He makes a determination of where the neck pain is based on exam, history, imaging review, and then with that he'll decide where he thinks the neck pain is coming from. He'll want to have some sort of objective evidence to say that that is where the pain is coming from, so he'll do a block under X-ray to make sure that, in fact, her pain is coming from that area.
Q Flip to Bates stamp number 11 there. I have

Page 13

highlighted that Dr. Ong appears to be an interventional pain management doctor.
Is that your understanding?
A That is correct.
Q Is it common in your experience, Doctor, for someone who has neck pain who undergoes a series of physical therapy and does not get relief to then be referred to a pain management specialist?
A It's very common.
Q What I would like to do now, at this point I think we're starting to get into some of your notes. Bates stamp number 12 there, Doctor, if you could. The date on that is July 12 of 2018.
Do you see that?
A I do.
Q Do you believe this to be the first office visit that you had with Ms. Gard?
A I believe so.
Q And what were some of the problems, if any, that she was explaining to you at that point?
A The main issue is she was having chronic neck pain.
Q If you flip the page to Bates stamp 13 there, does this discuss some of the facet joint

Page 14

injections that she was having and talk about the relief that she was receiving, and, if so, can you explain that, please?

A Yeah. So she had the medial branch block, and she reported she had at least 50 percent pain relief.

Q Can you explain in your experience, Doctor, the -- how typical is that, for someone to get 50 percent relief? Is that typical? Atypical? Can you talk about that?

A I mean, if they're able to identify the proper location and if the person is a reasonably responding individual -- because some people just don't respond to injections -- they should at least get 50 percent, and it's very reasonable to expect that.

Q If you could now flip to page 17, which I think is the last or second-to-last page, maybe, of your visit.

What was the plan or course of action that you establish with Ms. Gard at your first visit?

A So on our first visit we wanted her to maximize her therapy with Dr. Ong, her treatments with Dr. Ong. She had gotten relief with the facet

Page 15

injections. Certainly it would have been reasonable for her to go back again. Because I think Dr. Ong and her had talked about a second round.

I know that this was potentially leading toward a more permanent solution called radiofrequency ablation, which is the permanent version of the medial branch block, which is a more temporary version, and I had steered her in that direction. I felt that that was more than appropriate for her to try to find the least invasive method for pain relief.

Q It also talks on number two here for the plan is to continue with Aleve.

Would that be a -- something that -- well, is that something you recommended at that time that she continue?

A Yeah. I mean, she was taking that, and then we said, "You know what, that sounds great. You know, if you're getting relief from that, let's continue that." And I also said, you know, she could try other therapies like Lidoderm patches and so forth.

Q If you could now turn to the next page, which is Bates stamped 18, Doctor. This appears to be a

Page 16

date of service from August 9th of 2018, and it looks like another operative note of sorts from Dr. Ong.

Would you agree with that?

A Yes.

Q And from this document could you tell what procedure we're talking about here?

A He says he's doing medial branch blocks.

Q Is it common to -- for a patient to undergo multiple medial branch blocks?

A In fact, it is, because you want to be able to have reproducibility to finding the location of pain gene- -- to find the pain generator. It is possible if you do it only once that you may have just mistakenly thought that that's the level, because sometimes the medication could spread, sometimes you could be off. I mean, there is so many different variables. So by repeating it and getting the same result, it increases the confidence of your original findings.

Q Okay. If you now flip to Bates stamp 20, and this appears to be another office visit from you dated August 22nd of 2018.

Would you agree with that?

Page 17

A Yes.

Q Flip the page to Bates stamp 21 there. I take this to be part of the history and discussion that you're having with Ms. Gard at this visit.

Is that a fair statement?

A Yes, it is.

Q And what was your advice or what was the plan or course of action that you establish with Ms. Gard at that time?

A Yeah. So at that time she says her pain is a little bit more tolerable. She said she didn't have neck pain before the accident. She wanted to know what would be a long-term option down the road, and I think we had talked about surgery. She wasn't interested in surgery at that moment, and she thought that she could continue to manage her pain without open surgery. And we certainly were fine with that. We, in fact, always support that whenever possible.

Q And perhaps my question would have been better served after we looked at page 25, so I'm going to have you briefly read the bottom highlighted part there, and can you let us know when you've had a chance to read that.

Page 18

A Okay. So in this paragraph we had a discussion about the possibility of future surgery. And even though she was managing -- and certainly, again, we are supportive of that. It seemed like she was always having breakthrough pain, and I felt that at some point surgery may be indicated.

Q But at this time in August of 2018, it was not yet recommended by you, is that a fair statement?

A I think at that point I didn't feel that she had to have surgery. In her mind she wanted to maximize everything nonsurgical, and I think that there is so many factors that come into making a surgical recommendation. When it's for pain specifically, the patient has to be in that mindset as well, and I think she wasn't.

And so we really knew that it was not critical that she have surgery that day. It wasn't like she was, you know, in the midst of being paralyzed. We felt that since this would be for pain that most likely she will need surgery down the road, but that -- the timing of that would have to be based on what she felt comfortable with.

Page 19

Q At that point in your opinion was it reasonable for her to push off the surgery and try other conservative --

A Absolutely.

Q -- remedies?

A Absolutely. Yes. Absolutely.

Q It appears here under the plan that you recommend that she continue with Dr. Ong.

Is that a fair statement?

A Yes.

Q And then also order -- in plan three there it looks like order another CT of the cervical spine.

Is that to see if there is any progression of her problem?

A Yeah. So one of the things that we can see in CAT scans that we can't always see on MRI is we can see damage that MRI won't show. So if there is facet damage, which is the area that Dr. Ong was injecting, we can sometimes see black streaks in the facet joints, and that's what I was looking for.

Q Gotcha. If we could then turn to page Bates stamp 33, please. This appears to be an operative note of Dr. Ong again dated

Page 20

November 15 of 2018.

Do you see that?

A Yes.

Q It appears that at least per this document that it says "The patient has underlying facet joint arthropathy."

Can you explain what that means?

A Yeah. So it just means there is disease or some damage to the facet joint.

Q What is the procedure that is indicated here on Bates stamp 33?

A Yeah. So this procedure he's describing is radiofrequency ablation of the nerve endings around the -- at or around the facet joints to alleviate pain.

Q I've heard radiofrequency ablation is a nerve burning procedure. Is there some correlation there, or am I making that up?

A No. So, unfortunately, it's called nerve burning. You're technically not burning any nerves. You're destroying nerve endings, which are pain receptors which are connected through tiny filaments to the actual large nerve bundle. So the large nerve bundle itself is not damaged.

Q Gotcha. If you could then flip to Bates stamp

Page 21

37, please. This is a date of service from November 29 of 2018. It looks like another radiofrequency ablation, although this one targets the left side of C4, C5, and C6, whereas the prior one was the right side.

Is that common for there to be two of those procedures within a two-week time span, one targeting each side?

A Yeah. And this is probably based on Dr. Ong's experience. He probably felt that he wanted to try one side, see how effective it was, and then go to the other side.

Q Are we still within the realm of what you would call a reasonable course of care for Ms. Gard, based on the injuries that you observed?

A Absolutely.

Q If we could now turn to Bates stamp number 39, please. This appears to be another office visit from your office dated December 5 of 2018.

Would you agree with that?

A I agree.

Q And then the stuff I want to talk about is on Bates stamp 43, if you could flip to that, and there is some stuff I highlighted on page 43 and 44.

Page 22

Can you explain the recommendations that you made to Ms. Gard at that time, please.

Well, let me back up. Let me withdraw the question.

The first question I want to ask you is what was the discussion you were having with Ms. Gard at that time based on the feedback you were getting from her with the conservative treatment she had received up to that point?

A I mean, she was -- she was responding to the injections and the radiofrequency. I mean, she was getting better.

Q Is it common for someone to have temporary relief from those radiofrequency ablations?

A Yeah. Absolutely. We can't promise how long those will last. You know, sometimes they last weeks, sometimes they last months, and anywhere in between. So that's very much variable on the person.

Q The next page there I have one sentence highlighted. It appears now that the topic of a surgical procedure is starting to pop up.

Is there any correlation between the timing of this, meaning you're now talking to her about surgery after she's done the

Page 23

conservative measures? Is that typical or atypical?

A It's very typical when the patient asks or if the patient is concerned about long-term management. And there was several issues that came up. You know, she wanted to know what -- would she have to do radiofrequency over and over, and I said certainly that would be possible. She was concerned about, you know, would surgery give her that permanency, and I said yes. She wanted to know if there were any risks, and I said absolutely.

And so we kind of had all the different things, and it took multiple conversations to just finally sort of come to the conclusion that surgery was the thing that she wanted to pursue.

Q Gotcha. If you can flip the page to page 45. This is an office visit from December 19 of 2018 with Dr. Ong.

Would you agree with that?

A I agree.

Q It appears here that -- per this record that Ms. Gard obtained initially 50 percent pain relief from the procedure. Now she was down to

Page 24

30 percent.

I think we talked about it a little bit, but is that a common phenomenon you see in your patients that have these types of procedures?

A Yeah. I mean, there is certainly a temporary nature to all these needle procedures and the radiofrequency. I mean, it's possible that it could have lasted longer. I mean, it's not unheard of for it to last several months to a year, and it's certainly possible that it only lasts a few weeks.

Q The last sentence that I highlighted, it says "Continues to have neck pain radiating to both shoulders."

I understand that for you to evaluate what that really means you would want to see some imaging, but from a clinical standpoint with that comment there with her neck pain radiating to both shoulders, what does -- what does that indicate to you, if anything?

A It tells me that the area that was hurting from the very beginning is still continuing to hurt her at this point.

Q The next document is -- that I would like to

Page 25

draw your attention to, Doctor, is Bates stamp number 48, please. This appears to be an office visit from February 27 of 2019.

Would you agree with that?

A I agree.

Q And then if you turn to Bates stamp number 53 on that, I highlighted some things, and it appears that from my recording of this page here that the option of surgery or the recommendation of surgery, you're getting closer to that.

Can you comment on that?

A Yeah. I mean, I think at this point, you know, she says she still has persistent symptoms.

Q And I may interrupt. What were the symptoms per this note that she was reporting at that time?

A Well, pain in the neck going into the shoulder, into the trapezius muscles, which is just muscles between the shoulder and the neck, and then pain going into the shoulder blade. She feels that it just feels uncomfortable with just normal daily activities. So those were the main symptoms.

Q I note here from my reading that the MRI appears that she has significant disease at C5 and C6.

What do you mean by that?

Page 26

A I mean there is -- there is an -- there is -- the disc at C5-6 is abnormal, and based on where the radiofrequency was, based on what the MRI was, we felt that C5-6 was our target.

Q Okay. The next note is page 54, if you can turn to that. It appears that office visit is October 30th of 2019.

Do you see that?

A Yes.

Q Flip the page here to page 56. It appears now -- we're in October of 2019 -- that you are now making the official recommendation of a surgery.

Can you please confirm that's true, and, if so, what surgery were you recommending and why?

A Yeah. We're recommending -- so we were recommending a fusion surgery at the C5-6. We recommended it from the front.

Q Why?

A The -- the disc at C5-6 appeared abnormal. We can do a fusion at 5-6 from the front and get the most stabilization of the C5-6 segment. We could certainly approach it from the back of the spine, which is the direction Dr. Ong went in

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with the needles. However, you have to disrupt more muscle tissue, and the recovery is longer.

So often when a fusion needs to be done and a choice -- you have a choice between the front or the back, most surgeons opt for the front because the recovery is faster and you seem -- you can get a little bit stronger stabilization.

Q It appears from page 56 here that prior to making that recommendation, you obtained some more diagnostic imaging in the form of an MRI.

Is that true, and why did you do that at that time?

A I don't remember when her prior MRI was, but typically we like to have a repeat MRI, if it's been many, many months from the prior imaging, just to see if there is any changes.

Q And it appears that from page 56 here that this was a situation where Ms. Gard didn't right away say she wanted to have the surgery. To the contrary, it looked like she wanted to just think about it for a little bit.

Is that true, and is that a common phenomenon you see?

A Absolutely. It's super common. In fact, we're -- we encourage every patient when we discuss surgery to -- you know, just to take some time out of the -- away from the doctor's office and think it through. We, in fact, tell every patient to do that.

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Q Okay. That brings us to page 58, if you can flip to 58, please. That appears to be a visit from you of November 20th of 2019.

Would you agree with that?

A I agree.

Q If you flip to the page 60 of that, it appears now the plan is to actually go through with the surgery.

Am I reading this correctly?

A That is correct.

Q And my guess is that this indicates Ms. Gard thought about it for a period of time and decided to call back and wanted to schedule the surgery.

Do I have that right?

A That is correct.

Q All right. And then the next one that I would like for you to turn your attention to is Bates stamp number 66. That appears to be your operative note of December 24th of 2019.

Page 29

Am I seeing that correctly?

A That is correct.

Q And using these documents and your memory and your expertise, can you explain with as much detail as you can the surgery that you performed on Ms. Gard.

A Yeah. So the procedure is called an anterior cervical discectomy and fusion. What we do is, after the patient is asleep on the table, we make an incision in the front of the neck. Using X-ray we identify the C5-6 level. We'll put small distraction pins into the body. It's just to open up the space a little bit to have room to work in. We'll bring in a microscope so we're able to magnify everything that we see.

And using instruments -- they're called curettes -- we just curette out all the disc space. We'll go to the back of the disc, we'll identify any nerves that are there and just check to see if the nerves are being pinched, and we'll free them.

Once that's done, the bone where the disc came from, we'll rough it up until we just get tiny bits of bleeding so that it will be likely to fuse.

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We'll put a spacer in there, and the spacer can be anything the surgeon chooses, whatever works and whatever the patient prefers. Often we'll fill it either with the patient's own bone or something called allograft, which is cadaver bone.

What I typically do is I do a mixture. I'll take bone from the surgery and then bone from a cadaver that's commercially available. We'll put it into the spacer, put it in there, and then we'll put a small plate that anchors everything together, and the plate is screwed into the bones.

Q So this was at C5 and C6, and I want to see if I have that correctly. This involves an incision into the front of the neck.

Can you use your finger there, kind of --

A Yeah.

Q -- you point to where the incision is.

A So most surgeons will make an incision on the right side, so we'll find the midline midpoint at the neck -- in men, 5-6 is not far from the Adam's apple -- and -- and we'll just go to the right of that, and so we'll make a linear

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incision, like, right here.

Q And am I correct in hearing you that one of the first things you do -- I'm not going to say it's the first, but -- is you identify the damaged disc, and you remove that disc?

A Yes.

Q And then you fill that space with either cadaver bone or the patient's actual bone; is that accurate?

A Correct. And we'll put that inside a structural spacer that's usually like a small little cylinder or small little box.

Q And correct me if I'm wrong, but I'm going to assume the idea behind this is once you remove that damaged disc and replace it with bone, the idea is the body is going to naturally fuse together, those bones will fuse together naturally; is that right?

A That is correct.

Q Are there any plates and screws involved in this, or no?

A Yes. So --

Q Can you describe that, please.

A Yeah. So what we'll do is after we put the interbody -- which is a box or a little

Page 32

cylinder -- on top of the C5 and C6 bones, we'll put a small plate. And the plate is made of titanium metal, and then there will be little holes in the plate for screws to go in and anchor the plate to the bone.

And typically these screws are -- we always use millimeter measurements, so they're, like, between 12 to 15 millimeters in length. And 25 millimeters is an inch, just to give you reference.

And so we'll put these screws in. They'll go into the bone, they'll screw in, they'll lock the plate down, and that will provide a bracing. It will internally brace the bones together. Similar to someone who is wearing an external collar or brace, this is an internal brace that will hold it all together.

Q Am I correct in assuming that that bracing promotes the idea of lack of -- or non-movement so that the bones can naturally fuse together better?

A Absolutely. Yeah. So you want those two bones -- the C5 and C6 bones -- not to move, and then the healing will occur. Once it fuses, the body will use the fusion of bone to prevent any

Page 33

further movement, and then the plate actually just becomes superfluous at some point.

Q Did she tolerate the surgery okay?

A Yes.

Q And then I have the next note here, page 69 -- do you see that? -- September 2 of 2020?

A Yes.

Q And this is a post-op visit, and I think on page 71 there is some comment that I would like for you to talk about. Yeah. It goes to the improvement noted by the patient at that time.

Can you tell the Court here, based on this note and Ms. Gard's perception, what she felt -- how much she felt she improved from the surgery?

A Yeah. So at this point she says she's about 20 percent better. You know, and we went through the questioning in every different way, and that was the number she came up with.

Q All right. One thing I skipped over, on page 67 you talk about the risks of the surgery.

What are the known, verifiable risk factors for the type of surgery Ms. Gard had?

A I mean, the risks are basically neurologic injury, injury to the nerves, to the spinal

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cord. There can be bleeding. There can be a spinal fluid leak. There can be injury to the soft tissue structures in the neck, that includes the vein, the artery that's there. There is other nerves in that area as well. There is the trachea, the esophagus, the thyroid. I mean, all these structures are right there, and certainly they're at risk for injury.

There can be a risk of bleeding after the surgery where you would have to go back in and remove the blood clot. And usually you see that within the first day -- day of the surgery. Infection certainly is a risk. There is a risk that she doesn't fuse, and the metal plate I put in can break. So these are the big risks specific to the surgery.

And then there is general risks. You know, she could have a heart attack. She could have a blood clot in the leg that can go to the lung. She can get pneumonia. You know, all these other general risks.

Q Is it also a risk of this surgery that it may not work to the patient's satisfaction, meaning the patient may not get the relief that he or she had hoped for?

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A That's always a risk. Absolutely. And I think that with every patient we're very clear on that and we just say, you know, we feel that statistically this is what should happen, but I said, you know, I can never guarantee it. And I think with Sheila, you know, as you can see, we took a slow train to surgery. You know, we never ever said to her, "You've got to choose now" or "Let's just jump to surgery." We purposely take a slow train because this is a very thoughtful process.

Q Those risk factors that we just described there in the past couple minutes, are those risk factors that were explained to Ms. Gard?

A Yes.

Q Prior to surgery?

A Yes.

Q All right. A couple things that I want to go over, Doctor. I talked about the physical therapy records, but I didn't give you a chance to go -- to look through those, and nor did I go over those in any great detail. I would like to turn your attention to Exhibit 5.

I don't want you to go through these, but if you could just generally breeze through these, do these appear to you to be physical therapy records pertaining to Ms. Gard from various Aurora facilities?

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A Yes.

Q And, again, I'll represent to you this physical therapy time frame was from roughly April of 2017 extending into early 2018.

With that representation, would that be a reasonable time period for Ms. Gard to undergo physical therapy?

A Absolutely.

Q The treatment that we have gone over today from the ER -- or excuse me -- the urgent care, the primary doctor, physical therapy, Dr. Ong, and then the visits with you, do you believe all of that treatment to be reasonable and necessary to address the injuries that Ms. Gard sustained in this March 24th of 2017 accident?

A Absolutely. It's -- it's the standard of care.

Q All right. Next I want to draw your attention to Exhibit 6.

Have you had a chance to review this document prior to today's deposition?

A Yes.

Q Before we get into that specifically, I want to get a little background.

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You are a medical doctor, you are not necessarily a billing expert, you have people in your office to do that for you; is that correct?

A That is correct.

Q Are you generally aware of the various costs for various procedures that your patients undergo?

A In general, yeah. I mean, never the specific exact amounts, but I have a general idea.

Q All right. What I would like to do, then, is draw your attention to Exhibit 6, and I'll represent to you that this is a graph that my office made based upon the actual certified medical bills that will be part of Exhibit 2 at trial.

With that background and that representation, I would like to draw your attention to the left-hand column of this document. How this document works here, it's two pages, and the first column on the left-hand side of page one of Exhibit 6 then goes onto the second page of Exhibit 6, and it runs a total there.

Do you understand what I'm getting at Doctor?

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A I do. I do.
Q Okay. And I would like for you to just briefly look through those charges on the left-hand column there, both page one and two. It includes urgent care, facet joint prices, physical therapy, and some imaging.
Do you see that, Doctor?
A I do.
Q And the bottom the total there is $80,878.92.
Do you see that?
A I do.
Q Do you agree that those are generally reasonable charges for those procedures, Doctor?
A Yeah. I mean, I realize that, you know, these are large numbers, but that is in line with what I've seen with -- from other centers, other practices, so that's well within the normal range.
Q All right. The same questions I'm going to have with respect to a couple different graphs here.
Do you see Wisconsin Radiology, do you see that segment there?
A I do.
Q Do you see the Metropolitan Anesthesiologists?
A I do.

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Q Do you see the Columbia St. Mary's charges there?
A I do.
Q I'm going to assume that Wisconsin Radiology and Metropolitan Anesthesiologists are various anesthesiology or radiology groups.
Would you agree with that?
A Yes.
Q And those charges seem to be about -- well, exactly $76 and $10,868.
Do you see those numbers?
A I do.
Q Do you agree that those are generally reasonable prices for those services?
A I agree.
Q The Columbia St. Mary's, that indicates it's from the surgery and hospital stay. Those dates correlate with the dates we just talked about for the fusion surgery, so I'll call these the facility charge, and that facility charge is $34,822.59.
Do you see that?
A I do.
Q Do you agree that that is a reasonable charge for the surgery facility charge and the hospital stay relative to the surgery you performed?
A I do.
Q And the last topic of discussion with Exhibit 6 here are your charges, and that's on the top right of page 1 of Exhibit 6. It details office visits and then eventually a surgeons' charge and then a couple more office visits.
Do you see that?
A Yes, I do.
Q And the total there is $103,127.
Do you see that?
A Yes.
Q And do you believe your charges for the services you performed on Ms. Gard are reasonable in nature?
A I do.
Q Okay. Doctor, you understand that various providers can charge various different price tags for the same surgeries?
A Yes.
Q And is that, in fact, a common phenomenon to your knowledge, that various neurosurgeons in the community may charge different prices for same or similar services?
A Yeah. I mean, I think the neurosurgeons

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generally don't talk to each other about pricing. I mean, to some degree we can't because there would be a collusion issue. But I think that everyone tries to charge what they believe a fair price based on their practice experience and the services they offer.
MR. KNOBLOCH: Okay. At this point I would like to move into evidence Exhibit 3, 4, 5, 6, 7, and 8.
Any objection?
MR. PAWLAK: Yeah. I would like to object until I have an opportunity to cross-examine him about these exhibits, and then we can take that up afterwards.
MR. KNOBLOCH: Okay.
BY MR. KNOBLOCH:
Q Doctor, have all of your opinions today been to a reasonable degree of medical certainty?
A Yes.
MR. KNOBLOCH: Subject to moving these into evidence, I have no further questions for this doctor.
MR. PAWLAK: Thank you.
EXAMINATION

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BY MR. PAWLAK:
Q Let's start with Exhibit 6, where we finished off here. Can you tell us why under the Metropolitan Anesthesiologists there are two identical itemizations for $5,434?
A I can't tell you that because I didn't generate the bill.
Q Okay.
A Nor I did personally review the bill. All I have is the number in front of me.
Q So really, although you testified you believe these were reasonable, you really have a complete lack of foundation here to comment whether these are reasonable prices?
MR. KNOBLOCH: Objection to form.
THE WITNESS: I don't have a detailed review of what the charges are. I know that roughly in the market I think these are approximately reasonable. If you said to me, you know, "What is an anesthesiologist supposed to charge?" I couldn't tell you, because I'm not an anesthesiologist.
BY MR. PAWLAK:
Q Okay. Exactly. Well, as you're looking at this from whatever -- whatever basis that you're

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making, you're offering this opinion, when does the anesthesiologist -- at what point does the anesthesiologist fee become unreasonable?
A I think you would have to ask an anesthesiologist.
Q Okay. So then you would agree with me you really have no basis to comment on whether or not this anesthesiologist fee was reasonable?
MR. KNOBLOCH: Objection to form.
THE WITNESS: I think my basis is on, you know, approximately, it's a physician providing a service for X amount of period of time. You know, it's an approximate number, I could say that it's reasonable.
Because if you said to me, "What are they doing?" you know, I would say, "Yeah, they're keeping the patient alive, they're -- they're accepting a risk." I mean, there is a lot of time investment, and they have to do postoperative care. I think that if you said to me, you know, given the fact that in medicine what we charge, you know, they're going to change about this number, I would say relative to everyone else, that seems reasonable.
Now, we have to also remember, you

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know, a lot of the charged amounts that are submitted to insurance companies, we don't get paid this. So, you know, there is charged -- there is billed amounts, and then there is whatever you get billed. And so, you know, these numbers are generated by all practices. Everyone has their way of developing their numbers, and I'm telling you, relative to all other charges, I would say this is reasonable.
BY MR. PAWLAK:
Q Okay. So before we get to how you generate your numbers -- that's a great segue -- let me go back to one more point.
So, for example, here, the hospital stay is at 34,822. You've testified that you believe that was reasonable; is that correct?
A Correct.
Q What are you basing that upon?
A Again, based on what I've heard other facilities charge. You know, I've seen facilities charge more than this, and so to me that seemed a reasonable number. I mean, I wouldn't have been shocked -- shocked. I've seen Aurora charge double this.
Q Okay. So at what point would you be shocked?

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100,000? 150? A quarter million? What would be unreasonable in your opinion, based upon your knowledge and experience in this area?
A I mean, I think that, you know, certainly if they got to a number that was significantly higher, so maybe over 100,000.
Q Okay. So how do you set your fees?
A So our fees were set many, many years ago by my billing manager. So 20 years ago we started the practice and it was part of a larger group of neurosurgeons and they had their fees, and we really couldn't share fee numbers. We were told, you know, "You have to set your fees."
So I had a billing manager start, and she -- she checked national fee numbers, and then she set my fees. And then every year -- and this was 20 years ago, this is 2001, 2002, 2003, roughly in there -- she gradually increased the fees based upon what insurance companies allowed, based upon national trends, based on inflation.
And just over the years she has, you know, roughly increased the fees, and she would say, "Hey, you know, Dr. Dagam, you've had the same fees for the last three years. You know, I

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think it's time we increase the fees a certain percentage," and I said, "Okay."

And she goes, "You know, I think, you know, the other neurosurgeons are increasing their fees, I've talked to other doctors," so she has increased the fees over 20 years, and this is kind of where we ended up.

I would say if -- you know, my fee numbers are based upon 20 years of practice, 20 years of experience, and the complexity of what we do. We do complex spine cases. Spine cases do generally charge more than other surgical cases. Spine cases, they generate -- they have higher RVU numbers. When you add them all up, the RVU numbers are much larger.

So if you base it on -- per -- you know, on the number of RV -- total RVUs, you know, we're going to have a larger bill. We've been around for 20 years. We have 20 years of experience. So I think all that kind of comes together. That's how we have generated our charges.

Q Please define what RVU is.

A Relative value unit. Again, I'm not a billing expert, but that's -- that's sort of the

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assigned value for any particular procedure you do. So doing a cervical fusion, each different part of the fusion has a value, a relative value. And so we're doing, like, at least -- if you look at the op. note, we're doing at least three or four different things.

And I think -- and I don't know if this fee also includes the assistant fee. I don't know. I don't know if that includes that.

Q Just to give you a preview, I will be addressing that issue, but I'm going to stick with this one for the time being.

So what's your billing manager's name, please?

A So my billing manager has changed. We've changed this year because of COVID. So it was originally Heidi Weber, but now it's Rhonda Nessler.

Q So is Heidi no longer working for you?

A No. Because of COVID, our practice reduced, and she wanted a bigger position, so she moved on.

Q So are you aware of where you are for charging for spine-type surgeries within the Milwaukee area? Are you high? You're low? You're in between?

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A I don't know because I don't ask other surgeons what their numbers are.

Q Okay. And have you ever heard, for example, of charging -- so, for example, you know, 110 or 120 percent of what Medicare would pay for a similar surgery?

A Could you repeat that.

Q Sure. Sure. You must be aware that Medicare sets prices, reimbursement rates for surgery; correct?

A Correct.

Q And I'm sure you've done similar surgeries here today for Medicare?

A Correct.

Q And they usually -- I know doctors complain about what Medicare pays?

A Yes.

Q All right. So if you were -- have you ever heard in private practice, capitalism rules in this country, we control what we want to charge for ourselves?

A Yes.

Q Have you ever heard of doctors setting -- for example, "I know what Medicare pays for this surgery, I'm going to charge 125 or 150 percent

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of what Medicare pays"? Have you ever done anything like that to your knowledge?

A I think, yes, to some degree I have heard that, where doctors will charge a multiple of what Medicare will pay. So it's not typically 1.2, 1.3, but it will typically be 2 to 3 times or even higher than that.

Q Okay.

A And that's what their -- and that would be what their billed amount is. So, again, our billed amounts are very different than what we get paid, you know, because if we submit a bill -- we'll submit the same charge to Medicare, but we'll just get Medicare reimbursement numbers, you know, et cetera.

Q Do you know whether you've been paid anything for these surgeries?

A I would have to ask my billers, because I don't know if I've been paid for this or not.

Q Okay. All right. So you don't know if your surgery is -- your prices that you charge are high/low for what you do, it's just based upon 20 years of cumulative surgery and your -- Heidi Weber adjusting the rates over those --

A Correct.

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Q -- 20 years?
A Correct.
Q Okay. All right. I'm going to give you what's been marked as Exhibit No. 9. It's described as a Patient History Detail for the neurological surgery that you did in this matter.
So Plaintiff's attorney submitted a document, Exhibit 6, which indicates your fees were 103,127. The document which I have in front of you, which is broken down into significant detail, indicates it's 101,527, so relatively close in the grand scheme of things; correct?
A Correct.
Q All right. So you indicated earlier, you asked whether or not the fees reflected in Exhibit 6 actually detailed the work done -- I think you used the word "assistant" in the surgery process?
A Yes.
Q And who was that assistant, and who is that person?
A Oh, yeah. So my physician assistant, Beau Boedecker.
Q So on this sheet there is obviously

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abbreviations used, and there is a provider column, it's P-R-O-V.
And you would agree that stands for "provider"; right?
A Correct.
Q And there are names listed. Your name, of course, is in full, D-A-G-A-M, which is your entire last name.
And then there is B-E-A-U-B, and whom does that remember to?
A That refers to the physician assistant, Beau Boedecker.
Q All right. And then we have on the far left side here the codes for the surgical procedures; is that correct?
A Correct. Yes.
Q And this is -- this is how typically billing works in America today. Every process you perform has to have a code assigned to it, and then you bill out for that?
A That is correct.
Q So, for example, although we've been referring to this as one surgery, this thing is broken down here into at least 17, 18-plus different components of that surgery that you performed

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that day?
A I don't know the exact number, but it is broken down into many components.
Q Yeah. I mean -- and if you don't want to trust my counting, feel free to count on your own. I mean, I'm just trying to hit the ballpark here.
A Sure. Sure. I know it's a multiple. Yes.
Q All right. So -- and each of these codes -- for example, let's look at the first code, 63081.
Are you familiar with that?
A Yes.
Q And what is that, if we can refer to it as one or two words to give it a --
A Yeah.
Q -- title?
A Yeah. It's called a corpectomy code.
Q Okay. So I looked through your report, and I never found a mention of a corpectomy.
Why is that?
A I don't know if the -- are you talking about the operative report?
Q Yeah. Yeah.
A I don't know where -- do you have a copy of it?
Q Well, I'll tell you what. I'm going to pull open -- we're still on the record here. I want

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to just, if you don't mind -- you -- let me do a little segue.
You previously testified in a deposition conducted by me; is that correct?
A I believe so.
Q Yes. And I have here the certified original copy of that, which is still in the plastic, and I'm going to open here today to use again so we don't duplicate this multiple times.
A Sorry. I was going through the wrong stack.
Q So I'm going to give to you what was previously marked as Exhibit No. 1 -- this might be -- in that deposition which was conducted on October 13, 2021, here at your same office of which we were present today. The -- your operative reports are in that exhibit pages 67 through 79.
Feel free to go to those pages and tell me if you mention anything called a corpectomy in there.
A Yeah. So I actually use the word "vertebrectomy," and that's basically the same thing.
Q Okay. Is there any difference between a corpectomy and a vertebrectomy whatsoever?

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A In my -- for me, no.
Q Okay. Would there be some other practitioners who might have a nuance on those meanings?
A There may be, but I don't know what that different would be.
Q Okay. So you talk about the partial C5 vertebrectomy and partial C6 vertebrectomy; is that correct?
A Correct.
Q Now, why was it important to note that the partial C5 was a decompression of the spinal cord of 55 percent and the partial C6 vertebrectomy -- vertebrectomy -- excuse me -- was a decompression of the spinal cord of 60 percent? What's the relevance and importance of those points?
A Yeah. So that kind of goes back to my billing manager. So when we were doing these reports, she has said to me, "Be as detailed and specific as you can." So it's not necessarily critical in this particular case, and it doesn't have necessarily a critical clinical application. It was more of a billing person.
Because what my billing manager would do is with other insurance companies they would

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often just not want to pay any codes, and then she would go back and say, "Well, Dr. Dagam very clearly specified in this operative report."
So she -- she had a long conversation with me one time. This was many years ago. She said, "You know, the more detailed you are" -- because originally when doctors do operative reports, we're kind of going through them quickly, you know. I mean, if it was up to me, this operative report would be, like, four sentences. You know, I just -- I would literally just give a very general description, and then obviously, you know, if anything -- any complication occurred, I would put that in there.
But with her, she said, "Look, you know, my job is hard enough, so I need you to be crazy detailed," so that -- that was the reason why we kind of go into that level of detail.
Q Are you aware that, in fact, if the -- if the decompression of the spinal cord is less than 50 percent, you can't charge as much?
A I don't know if that's the case, but she told me, "If you're going to do a partial, you know, don't" -- I don't know, she gave me some

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guidelines on it, so I said, "All right, well," I go, "I'm not going to say anything that obviously I didn't do," and she goes, "Yeah, absolutely not."
So when we go in there, we do what's necessary and then we dictate it. You know, so if we're taking out 50 percent, you know, we're like, all right, well, you know, she says, you know, just make it 51 percent, just go in there, and so I -- I kind of had to do what was necessary and then make this report have enough detail for her to be able to use it as whatever she needed to fight the insurance company on.
Q Is it also true that one of the nuances in the distinction or the definition between corpectomy and vertebrectomy is a corpectomy is over 50 percent --
A I don't --
Q -- by definition?
A Yeah, that I don't know. Yeah. To me vertebrectomy and corpectomy are very much the same.
Q So 63081 is we'll call it the corpectomy. And what is your assistant's name again, please?
A Beau Boedecker.

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Q Beau Boedecker. His charge amount for that was $7,365; is that accurate?
A Yes.
Q And then we go down to the second cor- -- help me with this, please -- corpectomy?
A Correct.
Q And that was performed by you; correct?
A Correct.
Q And you charged $20,251 for that?
A Correct.
Q Are you three times better than he is? Three times faster? What's the difference for the prices?
A Well, we work together.
Q Okay.
A Yeah. So he -- he's assisting me under the microscope. I'm working there. We're both working together. And so I -- you know, we have to do the corpectomy together.
Q Okay. So correct me if I'm wrong, but I envision you being the -- since you're the surgeon, I envision you doing all the cutting and the placing, and he's helping you out and assisting you in whatever way, shape, and form that you would deem necessary; correct?

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A That's correct.
Q So why do we split up this billing on the sheet? Why is this done? What's the story behind this?
A Well --
Q It looks as if he performed one set of the stuff and you performed the other?
A I think this is billing convention. So I don't set billing convention. I didn't invent it, nor do I enforce it. This is billing convention. This is the way billing is done.
If it was personally up to me, you know, I would say "This is what we did, pay me this amount," but this is how the system is set up, so that's why it's split up into all these different categories and there is charges for him, charges for me.
Q Okay. Let me get back to that. So describe to me literally what mechanically goes on. I know you did it earlier. But for the corpectomy, what qualifies, what procedure, what did you do to be able -- entitled you folks to bill under 63081 for the corpectomy?
A Well, we go in, we identify the disc space, remove the disc material. We feel underneath the vertebral bone. We feel that it's a little

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tight, so we want to start taking out bone. And in order to get that, we sometimes have to shave down from the top down. We do that. We take additional bone.
We have to even out the surfaces, so you have to remove additional bone for that. So there is a lot of shaping of the -- of the C5 and C6 vertebral bodies, one, to remove ligament, to remove any osteophytes, and to make it all even. Because if it's not even, then you can't put the fusion device inside it to get it to heal. So there is a lot of work to be done.
There is continuous bleeding, so the assistant is there to help suction any bleeding. He's there to help me hold tissue back. Because when he has to retract the esophagus and trachea in order for me to work, he's looking through there, he's identifying any additional bleeders that I may not see. He's suctioning.
So it's a symphony of two people working together. I can't do this case by myself. It's very difficult. And so without the -- without a highly skilled assistant -- because I can bring in an assistant, and if they don't have knowledge, if they're not skilled, if

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they're not familiar with the surgery, it's -- they're useless, you know.
So a brand new PA from PA school is no good. Beau, who has been in with -- who has been with me for, you know, hundreds of cases, hundreds, maybe thousands of cases, that's critical. His skill is critical. So, you know, maybe the numbers reflect that, you know, that experience, that information, the nuance.
You know, it's kind of like having someone who really has played the violin really well as a first and second violin, and together you have a symphony. And I'm not a musician, so I'm just -- my metaphor might be horrible, but that's literally what's happening.
Q Okay. Let's move on to the next one. 63082, do you know what that one is?
A That's the other vertebrectomy code for the other, the C6.
Q And can we assign a brief descriptor to that process?
A Same thing that happens to the C6 side, the other side of the disc space.
Q All right. Well, for example -- and you can correct me if I'm wrong, but 63081, there is one

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on top, and then there is one below --
A Correct.
Q -- for you, so -- and we said those were the corpectomies, one for the C5 and one for the C6; is that right?
A Well, 63081 is for the C5.
Q Okay.
A And then 63082 is for the C6.
Q All right. So what's the second 606301 [sic] down below for?
A You're talking about why are there two 63081s and --
Q Correct.
A Well, there is one 63081 for Beau.
Q Yes.
A And one for me.
Q Ah, but they include both C5s?
A Well, remember, I said that we both work together.
Q You both work together. Fine.
A And convention -- so I, again, did not invent billing convention, you're asking me questions --
Q Yeah.
A -- that really I am not the expert on.

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Q Yeah.
A The way it works is he and I both do the corpectomy.
Q Correct. I've got that. I understand that.
A And because we both work together, there is a bill for him, and there is a bill for me.
Q Okay. But 63082 is an entirely different code. Why would you use a different code for the same surgery, same -- one is a C5 and one is a C6, doesn't it make more sense that the 63081 down below is for the C6, for example?
A No. Because the coding -- again, not my policy, but the coding rules require that the other vertebral body get -- gets its own code and it's a different code and it's called the additional corpectomy code.
Q Okay. But I thought 63082 was for decompression. No?
A It -- yeah. It's for the corpectomy. Vertebrectomy and decompression of the cord. Yes.
Q Okay. So what I'm suggesting to you is that there is a series of numbers at the top of the different codes that were done for C5, and then we start again under your name, for example, for

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C6 with --
A No.
Q You don't see it that way?
A No.
Q Okay.
A And I think that maybe you're misinterpreting, and I don't know.
Q Well, that's what we're here to find out.
A So there is a set of codes for Beau, and so there is a 63081, 82, 22 -- I mean, a bunch of codes for Beau.
Q Yes.
A And then there is a bunch of codes for me.
Q Correct.
A And since he and I are both working together, we are required to bill each code to each provider, so you don't just -- so, I mean, if we're both working on the corpectomy, we have to bill each of us -- each of us separately.
Q Okay. So there is no breakdown, then, on this sheet for C5 and C6?
A Well, I think there is a breakdown because to me, you know, it doesn't -- it depends on which one you assign to which --
Q Yeah.

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A -- vertebral body. It doesn't say that 63081 is C5 --
Q No.
A -- or 63082 is C6. It doesn't say that. It just says that that's one corpectomy, and then the other one is the additional. And it really just depends on how you read the operative report.
Q So this is the question:
Are we breaking down this surgical procedure by C5 and C6, or are we breaking it down by provider, in this case by you and your assistant, Beau?
A I think -- I think you have to do both. I mean, I think that's -- again, that's the convention. We -- we are -- you know, we are not given a choice on how to bill this. This is the way billing is done.
Q All right. So what is 2251 [sic], then, what -- what -- what part of this entire process is that?
A That is the arthrodesis, which is basically getting the surface of the vertebral bodies prepared for the fusion so that you can put a spacer in there. So that means evening it out,

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taking -- making sure if there is any excess bleeding, that's taken care of. I mean, all those little things we have to do.
Q Okay. And that's commonly referred to as a fusion, perhaps?
A It could be.
Q Arthrodesis?
A It could be. Yeah. Arthrodesis is just the medical term.
Q Okay. And he charged 7,500, and you charged 20,625; is that correct?
A That is correct.
Q All right. And then 22853, do you know what that is?
A That's the -- getting the vertebral spacer ready.
Q Is that also referred to as the cage?
A Yes.
Q Describe that again, please.
A So we get a cage -- well, first we have to measure the size of the cage. We do trials. We get the cage. We fill it with bone from the patient, put cadaver bone in there. We put it into the -- we put it into the spacer, make sure it's large enough, but not too large. We tap it

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in and then make sure it's countersunk appropriately.
Q And his charge for that was 1,770, and your charge was 4,866; is that correct?
A That is correct.
Q And then we have 22845, do you remember what that is?
A Yeah. That's putting in the cervical plate.
Q And what is the plate, again, please?
A The plate is a titanium plate that we put on the surface of the C5 and C6, put screws in and anchor it to the bone.
Q And he charged $3,826 for that, and you charged $10,519 for that; is that correct?
A That is correct.
Q And there is a number of other codes in here, but there is only one of those. For example, 61783, do you know what that is for?
A Let me see here. Yeah. That's for -- so we spent time with preoperative planning, so that -- we can charge for that. And then we used some navigation, so we just took some X-rays and then we put it into a navigation system just to make sure our screws and our plate were as even as possible.

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Q Is that the so-called Stealth system?
A Yes.
Q And then 77003?
A That's for taking X-rays and interpreting the X-rays and so forth.
Q That's the fluoroscope?
A Yes.
Q And that was a charge of $987?
A Yes.
Q And, lastly, 69990?
A Yes.
Q That is for the --
A Use of operating microscope.
Q All right. And there is one fee for that for $3,420; is that correct?
A That is correct.
Q All right. So I'm going to hand you what's been marked as Exhibit No. 10.
Have you ever heard of consumer -- internet consumer services where you can check out what your doctor is going to charge you for a service?
A No, I've never heard of that.
Q So you would be surprised to find out where your price range is for services in the Milwaukee

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area?
A I don't do that, I haven't looked at it, so I wouldn't be shocked or surprised. I -- you know, I just don't do that.
Q Well, I'm going to hand you Exhibit No. 10, and Exhibit No. 10 is for code 63082, which I call the decompression. And it says the average cost for that procedure in the United States is around 1,300, and you charge 9,200 averagely, but -- which is less than what you charged in this case.
A Okay.
Q Is that surprising to you?
A I -- I don't know anything about this service, and I don't know how accurate they are, so I -- I mean, thank you for this piece of paper, but I really don't put a lot of faith in it.
Q Okay. Well, it's pretty accurate to you; isn't it? It lists pretty close to what you charged for this, although it's under, they were conservative here, you charged more than this in this particular procedure?
A And I don't know how they get their numbers.
Q Yeah. All right. And Beau -- Beau Boedecker's name is listed here and he's your assistant from

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this case and he's about a third of what your rate is; is that correct?
A Again, I don't know how it gets their numbers, and I'd have -- and I would have to do my own analysis to tell you --
Q Yeah.
A -- what our averages are.
Q Okay.
A So, I mean, again, thank you for this piece of paper, but --
Q Sure.
A -- again, I don't know how much weight I can put on this.
Q All right. I'm going to hand you what's marked as Exhibit No. 11, and 11 is for the 63081, the vertebrectomy or the corpectomy. And that -- once again, that lists your rate at 18,400, and the average for this surgery is 5,491.
Is that surprising to you, that you're over three times higher than the average?
A Again, I don't know what their numbers are. And, again, you know -- again, I don't know if that's the average for neurosurgeons with 20 years' experience. Is that the average, you know -- you know, we're -- who's in this

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average? You know, is it a -- is it a neurosurgeon in XYZ city who just started out? You know, I mean, we don't know what these numbers are.

You know, so I -- I think that absolutely there is going to be variation. Absolutely. But, you know what -- you know, there is going to be variation in car prices. There is variation in hotel prices. There is variation in airline prices. So absolutely there is going to be variation.

Q Lastly, I'm going to hand you what's been marked as Exhibit No. 12. That is the -- for the fusion, 22551 code. And there your price is listed at 18,750, with the average cost being about 5,500 in the United States.

Once again, I assume you would testify just as you did the previous two that --

A Yeah. Basically I don't know how -- how much -- how value this has -- how much value this has.

Q But this -- the price that's in here for all three of these is actually less than what you charged in the incident matter?

A The price is this is --

Q Yes.

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A -- less than what we charge --

Q In Exhibits 10, 11, and 12, the price they have for you, the average price, is less than what you charged in the incident matter here today?

A Yeah. But you don't know how they even come up with any of these numbers, you know. Is it from the year 2010? Is it from the year 2019? We don't know. So, I mean, it's great to print this from the internet. I -- I'm impressed that you're able to find it, but to me it has no value.

Q Well, thank you for the compliment, and I appreciate your opinion.

So going to -- back to the surgery in this question. You're a member of the North American Spine Society?

A I used to be. I stopped going to the meetings. I just didn't have time.

Q Okay. And tell us what that organization is.

A I think it's just an organization of spine surgeons throughout the country.

Q Okay. And what -- do you find any value? Do you attend their training seminars?

A I haven't gone because our surgeries -- I mean, we do cutting-edge surgeries, and I'm kind of at

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the point now where what I do doesn't necessarily get trained at their seminars, because you really can't learn from a two-day seminar how to do something very complicated, you know. And I used to go to these things a lot, and there is -- it's really just a taste of something. It doesn't really teach you anything.

So, you know, there wasn't a ton of value to go to that, so I pretty much keep my meetings to the American -- AANS, American Association of Neurological Surgeons. It's broader. It gives me both cranial and spine and peripheral nerve --

Q Okay.

A -- education.

Q Were you aware that the North American Spine Society publishes appropriate use criteria for the surgery that you performed on Ms. Gard here?

A I'm sure that they do.

Q You've heard of -- so it's called a checklist, that one should go and look through that checklist to see what -- for example, what the patient is exhibiting which could be objectively seen as necessitating the need for the surgery?

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A Sure. Sure.

Q Okay. And did you do that in this incident case?

A No, I didn't go through the checklist --

Q Okay.

A -- because a checklist doesn't always -- if you don't know what you're doing, then go to a checklist. You know, get a page out of a textbook, read it through, and then follow the recipe, you know. You know, if you're a Michelin star -- star chef -- and I'm not saying I'm a Michelin star neurosurgeon -- you know, they don't go to a recipe -- Julia Child's cookbook and say "How I do make XYZ?" You know, a lot of the stuff we do, you know, we use standard of care and common sense.

Q But where does the standard of care come from?

A Standard of care comes from talking to other neurosurgeons, from our meetings, textbooks, so forth, and cumulative experience.

Q So in this particular case, as I understand your testimony, the only proffered reason for this surgery was the subjective pain which Ms. Gard was suffering?

A Correct.

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Q So --
A And there was some abnormalities on the imaging, too.
Q Okay. And so just let me -- let me run down this checklist.
So there was no neurological deficit?
A No.
Q No indication of instability?
A No.
Q No persistent loss of feeling, weakness, or muscle control?
A No.
Q No evidence of nerve compression?
A No.
Q No radicular pain?
A No.
Q No neck pain causing weakness or pain in the arms?
A No.
Q No numbness -- no numbness, tingling, or weakness?
A No.
Q All right. So you did not have occasion to meet with Ms. Gard to a significant period -- excuse me -- a significant period after the motor

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vehicle accident?
A Can you be more specific with that question.
Q Yeah. For example, she didn't see you within the week or a month after the accident; fair?
A No. No, she did not.
Q There was a significant period of time that elapsed in the chronological history before she had an opportunity to see you after the accident, she was referred to you by other doctors; is that correct?
A That is correct.
Q All right. So what can you tell us, what was the injury in your opinion that the motor vehicle accident caused here that necessitated your surgery?
A I believe the injury caused damage to the disc and damage to the facet tissue behind the spinal cord at that -- at the levels that she had between 5 and 6.
Q And what objectively can you point us to, what CAT scan, what X-ray, what MRI which provides support to that opinion?
A Yeah. Our review of the MRI show that the C5-6 disc was abnormal looking. Additionally, Dr. Ong's diagnostic studies point to the fact

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that her pain improved when he treated those levels.
Q Okay. So that tells us where the pain is coming from. What is there out there that tells us this pain was caused by the motor vehicle accident?
A You know, I guess that's a great question. So I think you can't say based on that data that it was intrinsically for sure caused by the motor vehicle accident, because there is nothing on the imaging that has a little sign with an arrow pointing saying "Caused by the MVA." However, we never have that. We rarely do.
So all we have is history, and history of pain, both what she had before and after the accident, and the imaging, and so we have to put all that together. And so basically the narrative is that, you know, she didn't have the neck pain before the accident, she has it afterwards.
We -- certainly she goes through the entire gamut of non-surgical treatment, and really I think she wasn't looking for surgery, you know, and I wasn't looking to do surgery on her, as evidenced by our initial meetings. That

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wasn't the conclusion that we were jumping to.
And so I think, you know, the narrative is she approached this in a very reasonable manner and I think all her providers approached it reasonably and it wasn't until she got to the very end where she's, like, "You know what, I'm not getting 100 -- you know, I'm not getting the relief I really need, you know, let's discuss the surgical option." And -- and we talked about it. You know, there is no guarantees here.
Q So you often use the phrase "disease" throughout your reporting here to describe the area that was the situs of the surgery. Why do you call it a disease?
A It's just a general term. It's just -- because physicians treat disease. You know, I mean, it's a -- it can be an acute injury or disease. There is no subtext to that word, meaning that it's -- you know, I'm not implying that it's not related to the motor vehicle accident.
Q Is that a common -- common term for surgeons to use the word "disease," when they really mean an acute injury?
A Well, I think her injury -- because her

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injury -- when was her car -- when was her MVA accident? When was the surgery? The surgery was in 2019. So her accident was, was it in twenty --

Q Her -- the surgery was December 24th, 2019.

MR. KNOBLOCH: If I may, the accident was March 27th of 2017.

THE WITNESS: Okay. So it's been two years; right? Approximately two -- over two years. So, I mean, first and foremost, you know, we're -- I'm not treating an acute injury, you know, because I didn't even meet her until well after her motor vehicle accident, so I'm not treating an acute injury.

Number two, you know, we just -- I use the word "disease" because that's just -- you know, that's an easy term to use. And I think that certainly if you want to interpret that to mean something different, certainly you could do that, but in my mind, you know, she's got pain, she's got damage, and that's part of the disease. You know, that's part of the problem. So "disease" and "problem," you know, in my mind are interchangeable.

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BY MR. PAWLAK:

Q And do you think that's generally accepted in the medical profession, to use that term of art in such a fashion?

A I don't know. I mean, it might be. It may not be. I don't think it's super critical. I mean, perhaps it's critical for you, but I don't think it's super critical, because I think I know what I'm talking about.

MR. KNOBLOCH: And I have to correct the record. It's march 24th of 2017. I don't think it changes his testimony.

BY MR. PAWLAK:

Q Okay. So you also talk about degenerative changes throughout your reports in terms of describing the area that was the situs of the surgery, don't you?

A I may have mentioned some degenerative changes. Yeah. I have to see the exact wording and language. But, you know, at her age she's probably going to have some degenerative changes, and I think that is perfectly accurate to assume that.

Q And degenerative changes would be caused by disease, aren't those two terms more

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interchangeable than --

A I think to the common layman, yeah, you know, and certainly you can push that point. But in my interpretation "injury," "damage," "disease," I mean, that's -- you know, that's what I'm thinking.

Q Okay. Now, you talked earlier under direct examination that -- if I understood your testimony, that Ms. Gard was complaining that she wasn't receiving any permanent relief, and you talked about providing permanence with surgery?

A That was the goal.

Q Okay. And, in effect, you only had a 20 percent success with that; is that correct?

A That is correct.

Q So you did not achieve permanence?

A I didn't achieve a -- greater than 50 percent, which is what I believe to be roughly the standard, pain relief. Did we achieve permanence? I think permanence is more an issue of time. And so if she got 20 percent relief forever, then we did achieve permanence -- a modest permanence of pain relief.

So I think for me "permanence" means

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time, but I think your question is really the degree of permanence or the degree of pain relief. No. We didn't achieve a high level of pain relief. Did we -- did we achieve pain relief forever? We don't know because that -- you know, we have to wait for that to come through the wash.

Q And you haven't seen Ms. Gard for a significant amount of time; right?

A That is correct.

Q So you don't know what her situation is today; correct?

A I do not.

Q All right. Is there any objective evidence out there that you can point to that, in fact, Ms. Gard's physical abilities have improved since you performed the surgery?

A I don't have any information.

Q So when you say the goal -- you were -- if I understand your testimony, your goal was you thought the surgery would be a success if you could permanently reduce her pain by 50 percent; is that accurate?

A Yeah. I mean, initially -- so, I mean, the word "permanent" means that it's long-lasting

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relative to what she was achieving from the injections, and the goal was to achieve -- or the aim was to get at least 50 percent pain relief.

Q So why didn't you simply recommend that she continue with the facet procedures which she had achieved significant success with 50 percent improvement?

A Is your question why didn't I recommend that --

Q Yeah.

A -- instead of the surgery?

Q Yeah.

A We did. We, in fact, recommended that she continue that as long as she can. She was not getting relief long enough with the facet procedures, and facet procedures are -- especially radiofrequency, over time becomes less and less effective.

Q And is it the same with the ablation procedure?

A Yes. Yeah. So they become -- over time they become less effective.

Q Is she -- can she undergo these procedures even now, after the surgery?

A Yes. Yes, she can.

Q How is it that the ablation procedure, which as

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I understand you said you -- it removes or it desensitizes the nerve endings, do those nerve endings grow back eventually?

A Yes.

Q You talked earlier -- briefly talked about the physical therapy.

You -- you're not really familiar with the physical therapy procedure that she went through at all, are you?

A I'm not a therapist. No.

Q Okay. You don't know if she missed appointments?

A I do not.

Q And you don't know if she was urged to schedule additional appointments or how hard she worked at any of that; right?

A No. I was not there with her.

Q So how much have you been paid today for your -- today and any other cooperation you made with the plaintiff for your testimony in this regard?

A For today, I don't know. I would have to talk to my manager. She -- she processes all that.

Q Okay. Is that your booking agent or your manager?

A Kind of does both.

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Q So you don't know what you were paid today. Okay. And you don't know if you received any payment whatsoever for the surgery that you performed?

A Yeah. I -- I am assuming from Exhibit 9, if this is accurate -- and I don't know when this was -- so this looks like this was generated in March 2021. It says we haven't been paid.

Q Yeah. Okay.

A So if we haven't been paid by March 2021, I doubt that we got paid, you know, at all.

MR. PAWLAK: All right. That's all I have. Thanks.

EXAMINATION

BY MR. KNOBLOCH:

Q A couple follow-up, Doctor. You have Exhibit 9 there in front of you. We've had an extensive discussion today about the codes and whatnot. That discussion also included billing for your time and also billing for your assistant or your physician assistant's time. I want to talk about that concept in general.

Is it common in your experience, Doctor, for neurosurgeons or any surgeon to bill for their own time and also bill for an

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assistant's time?

A Yeah. So it depends on the practice. So there is a lot of practices where two neurosurgeons will work together, and the primary surgeon gets paid the lion's share of the fee, and then the assistant surgeon will get paid a fraction, whatever that may be.

Because practices have grown, because neurosurgeons are in short supply, often physician extenders, PAs, are now involved. And they -- and they -- what they do is no less skilled than what a second neurosurgeon would do, you know, and so a really good physician assistant can do pretty much what another neurosurgeon does. There is a lot of rules and regulations that they have to do it under supervision, but they're very skilled. So that's -- that's how it works.

Q Is it fair to say with respect to the codes and the procedures and what you can bill and how much you can bill and what codes for this -- this, that, and the other thing, are those ever-changing within your industry, would you say?

A I mean, the codes can change because it's all

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determined I guess by a larger body that determines these codes. So the code numbers can change, but the idea, the principles, don't change.

Q Regardless of your charges and the codes associated with them, do you have any reason to dispute that Ms. Gard was actually charged -- looking at Exhibit 9 -- this $101,527 by your office for the totality of the treatment received by you?

A I mean, yes, I believe that this -- these were the charges that were sent out.

Q What I was getting at is -- well, strike that question.

MR. KNOBLOCH: I would like to move those exhibits that I proffered earlier into evidence, but subject to that, I have nothing further.

Any objection to that?

MR. PAWLAK: Well, I don't know if we want to keep -- I would like to have a discussion with you afterwards, or unless you want to do it now on the record now about those exhibits.

MR. KNOBLOCH: Well, how long it is it

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going to take? Let's -- I would prefer to do it on the record, so we don't have to brief it after.

MR. PAWLAK: Okay. Well, yeah. My issue is if your intention is to enter, like, for example, the physical therapy records based upon the testimony of this witness, yeah, I'm opposed to that.

I'm not necessarily opposed to you -- to us coming to a stipulation that those records can entered on the face of it for what they're worth, in the sense that she went to therapy on those days. I just object -- he doesn't have the foundation, I don't think, to say that that's reasonable based upon his -- his, you know, carefree review here today, and I don't think he possesses the expertise, as he's indicated there.

So, I mean, but I'm -- that being said, I think we can come to arrangement to get those in. Otherwise you can move and I can object and we can let the judge decide, but I think we can probably work that, depending on what you want to do with those physical -- if you just want to --

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MR. KNOBLOCH: Is your only objection to the therapy records?

MR. PAWLAK: What was the other one that he -- well, all of the other records, too, that he testified that were reasonable, it's my position that -- I'm not -- I'm not opposed to the document coming in for what it says on the face of it. I'm -- what I'm objecting to is his opinion that they're reasonable.

Now, we can let those documents in for face value, but I'm not agreeing that his testimony that they're reasonable is relevant. And I guess we can deal with that, if you're relying on that for some purpose.

MR. KNOBLOCH: Well, I'm trying to figure out the distinction.

MR. PAWLAK: Yeah. Yeah.

MR. KNOBLOCH: It's going to come in on its face, so the numbers are going to be heard by the Court.

MR. PAWLAK: The number is going to be heard.

MR. KNOBLOCH: The Court still has to make a determination on reasonableness.

MR. PAWLAK: Yeah.

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MR. KNOBLOCH: I think there was enough foundation, shaky or not, that his testimony comes in, and I think your cross goes to the weight of the evidence, not to the admissibility of it, so I think it comes in, and the judge is going to have to weigh it all --

MR. PAWLAK: Okay.

MR. KNOBLOCH: -- and come to a reasonable number.

MR. PAWLAK: I will -- then what I will do is I will --

MR. KNOBLOCH: We're almost done, Doctor.

MR. PAWLAK: Yeah. I'm going to -- I'm going to keep my objection there, then, based upon that provision that it goes to the weight of it. So if I think if I -- I'm going to have to preserve that objection. If she says it comes in and then she decides the weight based upon the direct and the cross, then we can deal with that. So I'm going to -- I'm going to keep my objection.

MR. KNOBLOCH: As to what specifically?

MR. PAWLAK: Well, I'm going to keep

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it to the physical therapy -- I'm going to keep it to the physical therapy records. If you're relying upon him to get those into the record, that's -- that's my -- that's the crux of my objection.

MR. KNOBLOCH: Okay.

MR. PAWLAK: I don't buy his testimony that they're reasonable. If they have to be reasonable to come into the record, then I'm objecting to it, I guess, because I don't think they're reasonable. That's part of my argument in this case.

MR. KNOBLOCH: But we're focused just on the therapy at this point?

MR. PAWLAK: Therapy record and -- well, of course, all of his charges, too. I mean, they're there. I agree that they happened, obviously. We know that they were billed out. I'm objecting on the issue of their reasonableness.

MR. KNOBLOCH: Sure. You can preserve all objections --

MR. PAWLAK: Okay.

MR. KNOBLOCH: -- to reasonableness --

MR. PAWLAK: Yeah.

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MR. KNOBLOCH: -- because that's, in my mind, a jury question or a Court question --

MR. PAWLAK: Yeah.

MR. KNOBLOCH: -- so I don't know if you're -- you need to place it.

But as far as the admissibility of these documents, that's what I would like to get straightened out here on the record. So I would like to move those --

MR. PAWLAK: Yeah.

MR. KNOBLOCH: -- into evidence.

MR. PAWLAK: Okay. That's fine.

MR. KNOBLOCH: So no objection?

MR. PAWLAK: I think I've gone over backwards trying to preserve my --

MR. KNOBLOCH: So just to be clear, no objection to my exhibits --

MR. PAWLAK: Coming into the record. Right. Yeah.

MR. KNOBLOCH: Okay.

MR. PAWLAK: That's fine.

MR. KNOBLOCH: All right. I think we're done.

MR. PAWLAK: And then I'll -- excuse me. I'll move my exhibits in the record, too,

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for what they're -- for the same reason. The Judge can decide whether or not --

MR. KNOBLOCH: No objection.

MR. PAWLAK: -- what weight she wants to give them. Okay. Thank you.

MR. KNOBLOCH: All right. We're done.

THE VIDEOGRAPHER: We're going off the record. The time is 5:15 p.m. This concludes today's testimony. The total number of media units used today is one.

(Proceedings concluded at 5:15 p.m.)

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STATE OF WISCONSIN)
) SS:
COUNTY OF MILWAUKEE)

I, Sarah M. Gilkay, RPR, RMR, CRR, and Notary Public in and for the State of Wisconsin, do hereby certify that the preceding deposition was recorded by me and reduced to writing under my personal direction.

I further certify that I am not a relative or employee or attorney or counsel of any of the parties, or a relative or employee of such attorney or counsel, or financially interested directly or indirectly in this action.

In witness whereof, I have hereunder set my hand and affixed my seal of office on this 28th day of February, 2022.

<%26888,Signature%>

Sarah Gilkay
RPR, RMR, CRR, and Notary Public
My commission expires March 8th, 2026